

Chronic Pain Case Management in Opioid Patients: Improving Risk Management and Shifting Prescriber Behavior in a Rural Community Health Center

The Cube, 3rd floor, AS3-2119

Moderator:

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Presenters:

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Session Description

Outer Cape Health Services (OCHS) is an independent, federally-qualified health center with three locations in the outermost towns of Cape Cod, an area hit hard by the opiate epidemic of recent years. After years of updates to the OCHS Controlled Substance Policy and Procedure, Medical Director Dr. Barbara Prazak worked with the Director of Nursing to develop the Chronic Pain Case Management (CPCM) Program, to be implemented March 1, 2016. The CPCM program uses a team-based case management approach to monitoring patients on opioid prescriptions, with systematic tracking of patient data such as PEG scales, MEQ dosing, concurrent use of benzodiazepines, annual agreements, UDS and PMP checks and visit compliance, and regular provider-to-provider case reviews. While the CPCM program supports the primary care prescriber with consistent, data-based risk management and evaluation, it also aims to shift provider behavior and practices in opiate prescribing, towards an approach that is more collaborative, individualized to patients' needs, and integrated with primary care. Through this breakout session, we will engage with other prescriber teams to learn about other team-based approaches to chronic pain case management, discuss best practices, and begin formulating issues that warrant research.

Chronic Pain and Opiates: Shifting Prescriber Behavior

Lessons Learned, Evolving Strategies, New Questions

Outer Cape Health Services

Barbara Prazak MD, Medical Director

Tina Rauch RN, Nurse Manager, OCHS-Wellfleet

Jennifer Eldredge, Data Analyst

Ellen Dennehy, PA



Our objectives today

- * Outer Cape Health Services' story
 - * Change in use of opiates among patients & in the community
 - * Efforts to analyze and better understand opiate use
- * Chronic Pain Case Management program
 - * Policy and Procedure changes
 - * Optimizing risk management
 - * Team-building
 - * Shifting prescriber behavior
 - * Building/pivoting relationships with patients
- * Measures of success
- * Questions & Discussion



About OCHS

- * Created in 1987 with merger of Provincetown and Wellfleet
- * Rural FQHC
- * Eight outermost towns of Cape
- * 200 square-mile catchment area
- * Designated by HRSA as underserved for medical, dental, & mental health



OCHS-Provincetown

- 16 exam rooms
- CHC farthest from a hospital in Massachusetts (60 miles away)
- Renovated 2010

OCHS-Wellfleet

- 8 exam rooms
- Oldest CHC in Massachusetts (1966)
- Expansion slated for 2018

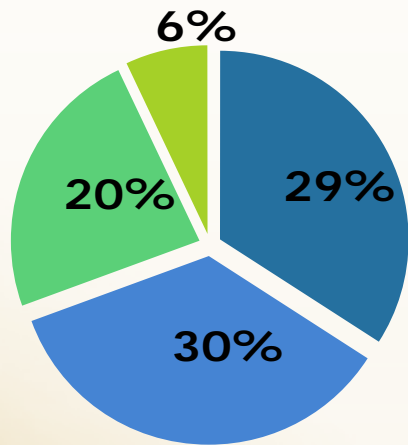
OCHS-Harwich

- 5 exam rooms
- Rental space; opened 2011
- Expansion slated for 2017

About OCHS

- * 17,000 unique patients seen in calendar year 2015
- * 16 PCPs (5 new in 2015-6), 21 MAs, 12 RNs
- * Team Ratios:
PCP:MA 1:1, PCP: RN 1:2

Payor mix



Largest and virtually only medical practice accepting adults with MassHealth beyond Hyannis

- Medicare
- Mass Health
- Commercial
- Uninsured



Chronic pain in perspective

- * 100 million in US with chronic pain
- * Chronic pain is a disease
- * Significant barriers to adequate care
 - * Negative attitudes and disparities
 - * Over-burdened primary care providers
 - * Increasing regulation at Federal and State levels
- * Perspectives are shifting
 - * New MA and CDC guidelines, public perceptions

Opioid efficacy for chronic pain

- * Most studies small, pharmaceutical-sponsored, do not assess addiction
- * **About 50% of patients shown to get 50% pain relief from opioids**
- * Patients have variable responses
 - * Different amounts of opioid receptors
 - * Differences in metabolism
- * Opioids only one tool for managing severe chronic pain
 - * May be indicated when alternative safer treatment options are inadequate

Opioids in the community

- * Overdose trends are increasing, locally and nationally
- * 30 overdoses on Cape Cod during 2014 Christmas season
- * Local news coverage of opiate issues increasing: crime, mis-use
- * HBO documentary *Heroin: Cape Cod, USA* drew national attention

Changes around opiate prescribing at OCHS: 2011-2016

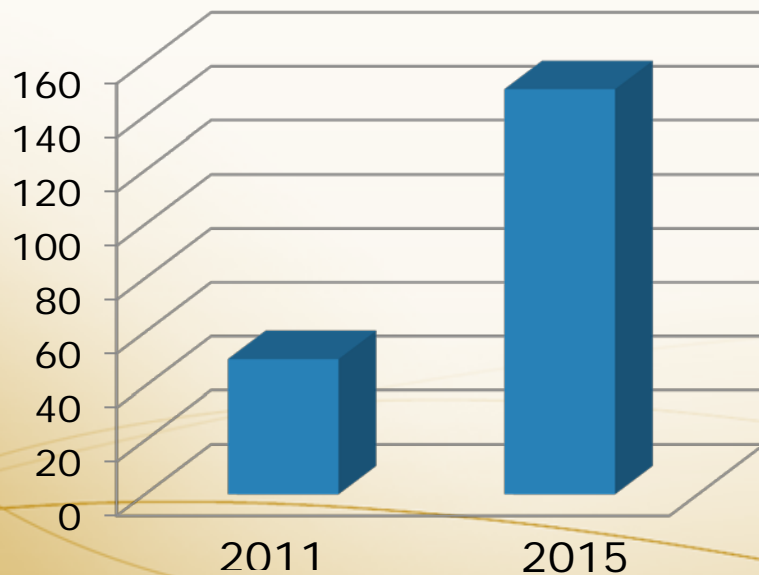
- Purchased a private practice in Harwich, 2011 to open our third site
- Lots of inherited chronic pain patients, stimulated our interest!
- Created opportunities for Case Discussion; formal, informal
- Speakers (Baystate Health, Dr. Jeff Baxter from UMass, Cape Cod Health Care)
- Revised Policy and Procedure (endlessly...☺)

Changes around opiate prescribing (cont.)

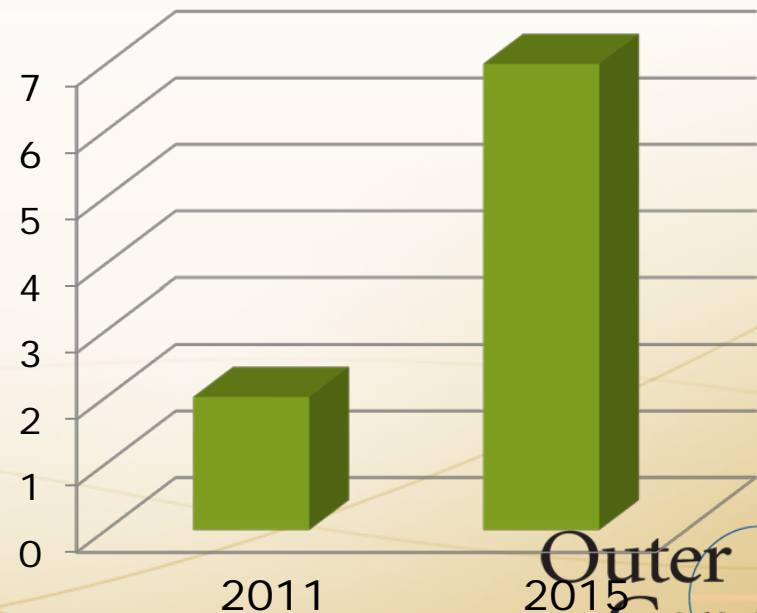
- Shared patients, shared guidelines, mentoring, collaboration
- Standardizing: Custom UDS, PMP delegates
- 2012 signage “*OCHS does not currently accept new patients requiring refills of opiates used for chronic non-cancer pain*”
- OCHS OBOT (Suboxone) program GREW
- Behavioral Health licensure 2015: 2 psychiatrists, 3 LIC SWs
- **Still, PCP resignations caused distress around opiates...**

OCHS Suboxone (OBOT) program

Patients



PCPs





Staff at Cranberry Festival 2015

Distress around opiate prescriptions

- * *“I don’t want to inherit that patient”*
- * Nurses’ concerns (Patient *“looked sedated at Rx pick up”*)
- * Patients doctor-shopping between OCHS PCPs around opiates
- * Complaints from both sides: from patients and providers to the Medical Director

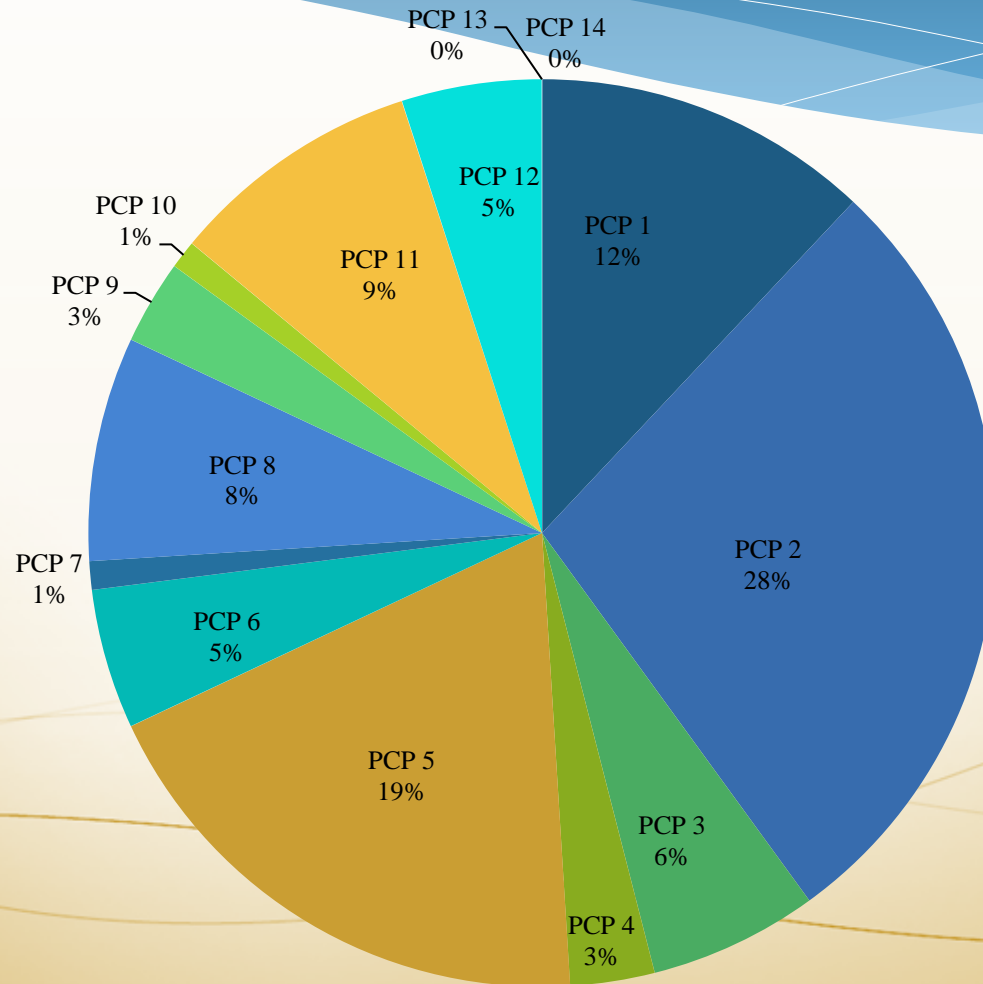
Looking at ourselves

- * Beginning June 2015
- * Grand Rounds: Dr. Phil Bolduc, Worcester FH CHC
- * Field trip to Worcester Family Health CHC
- * Collected patient names from RNs & PCPs
- * Created registry of >200 patients on opiates for chronic non-cancer pain, individualized for team RN case-mgmt
- * College volunteer invaluable- Julia

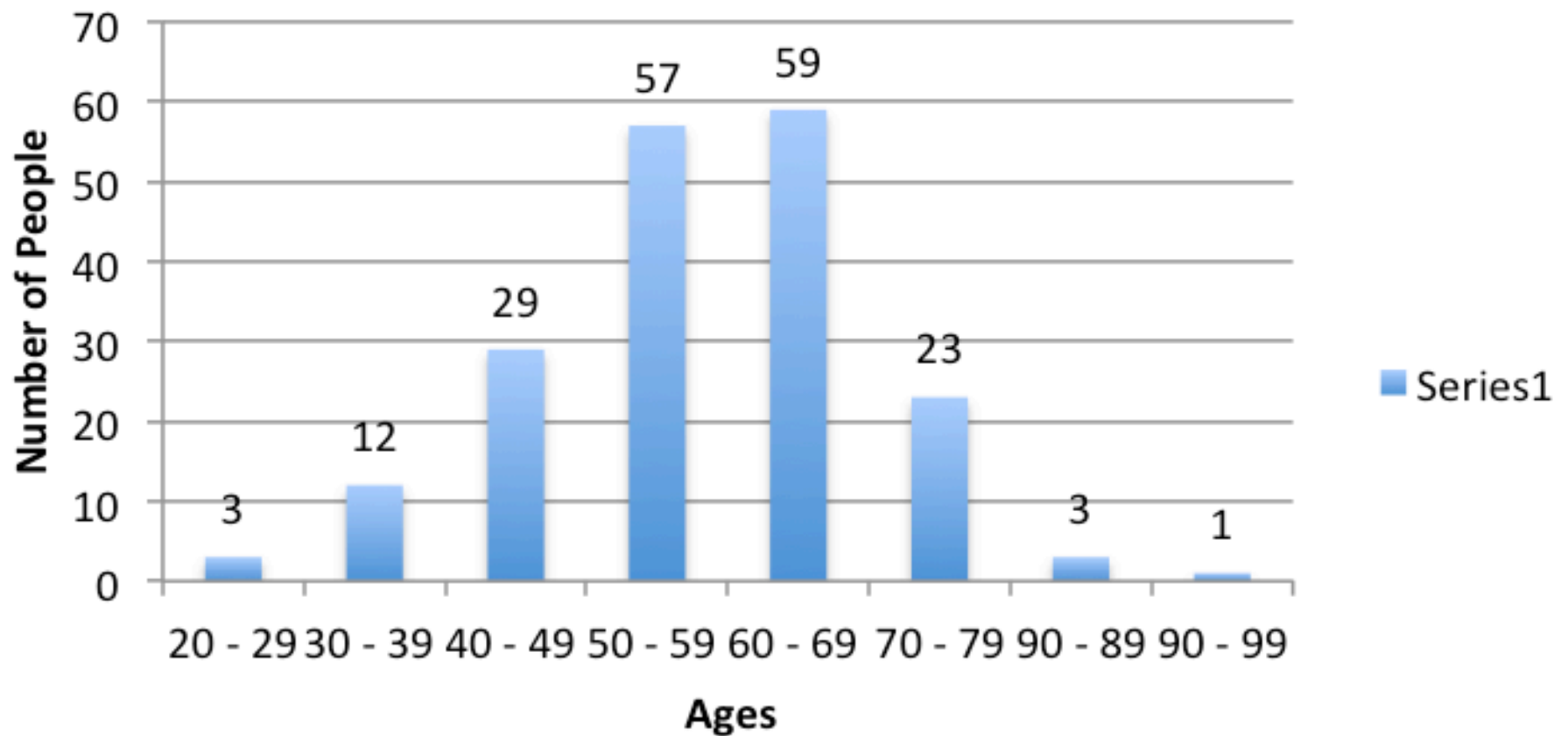
Chronic Pain Registry excerpt

D.O.B.	MEQ Dosage	Tier	Reason	Date Contract Annual	Last UDS	PMP Date	Psych Dx	Red Flag
/1983	127.5	1	Torticollis	7/22/2013	4/10/2012	None	Depression, major	
/1955	76	2	Back pain	10/25/2012	9/11/2014	None	Situational anxiety	
/1961	30	3	Knee pain	1/6/2014	7/8/2014	12/17/2013	Alcohol abuse, in remission	
/1950	15	3	Hip pain	4/15/2013	4/15/2013	None	None	
/1959	225	1	Back pain	11/3/2014	6/24/2014	None	Bipolar disorder	Lives in New Bedford
/1976	45	2	Chronic headaches	5/14/2014	8/6/2014	None	Cognitive deficits	
/1963	67.5	2	Lumbar spondylosis	5/21/2014	8/21/2011	None	None	

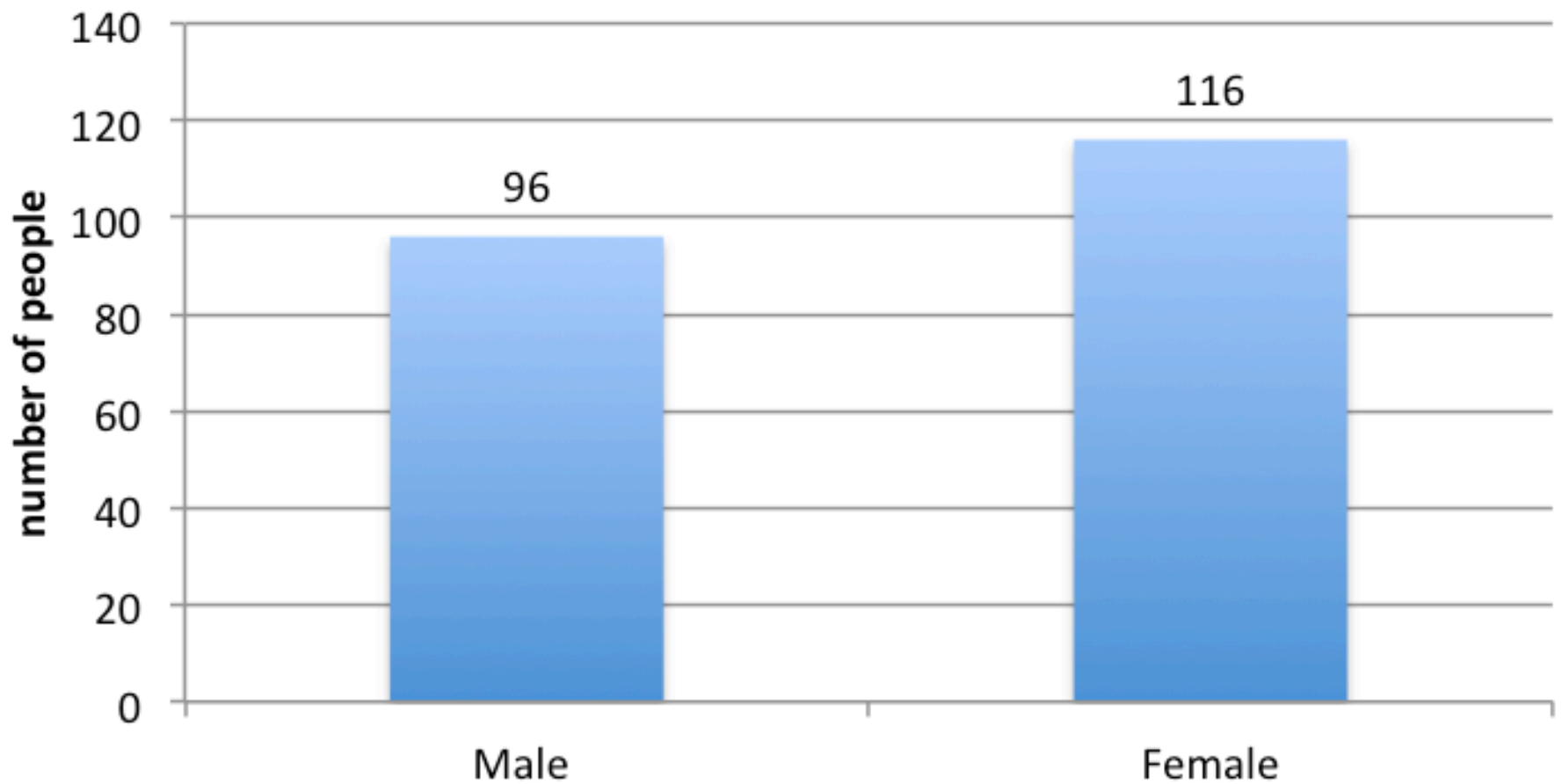
Patients on Opiates by PCP



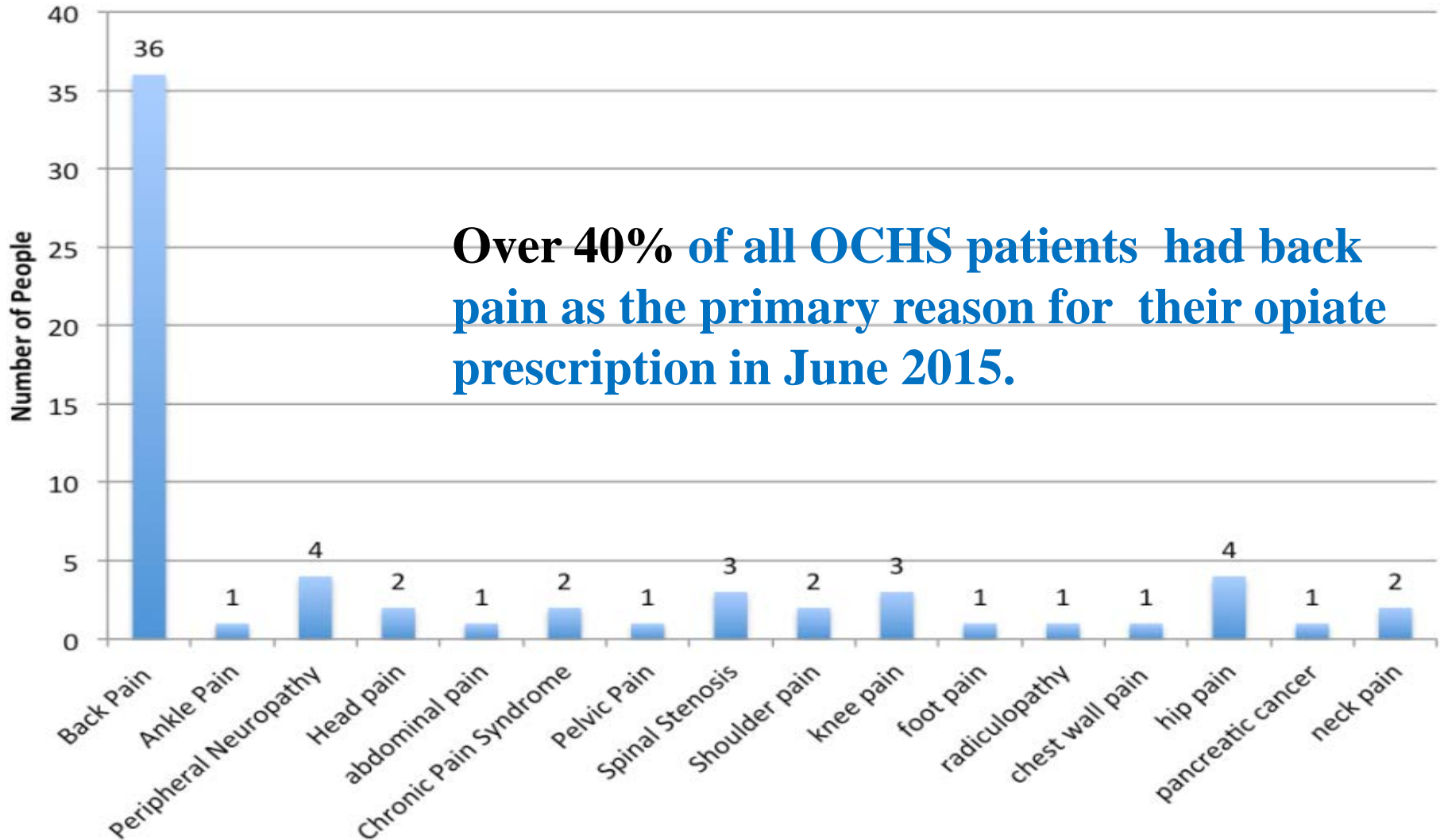
All OCHS Age Chart



All OCHS - Male v Female

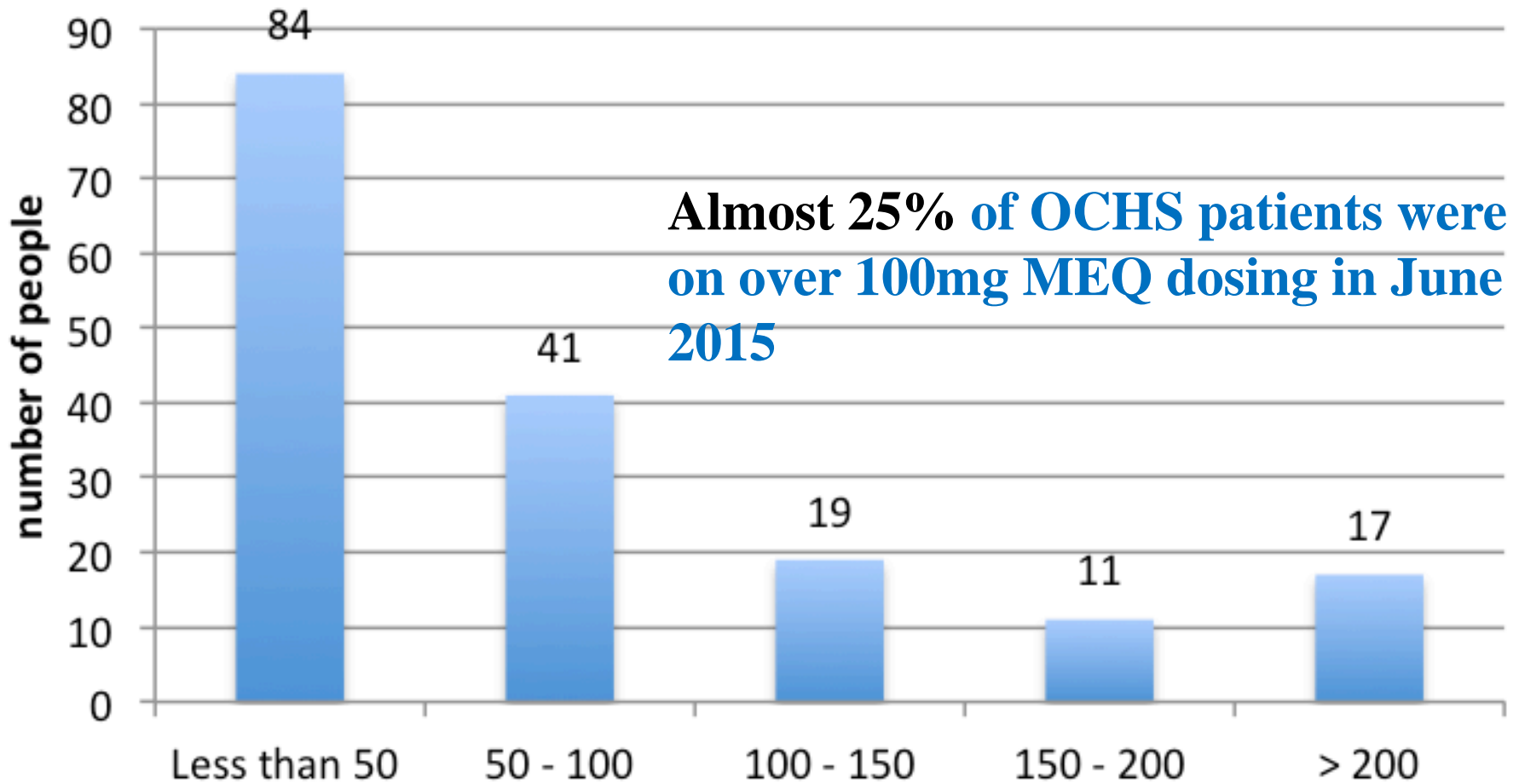


POCHS - Reasons

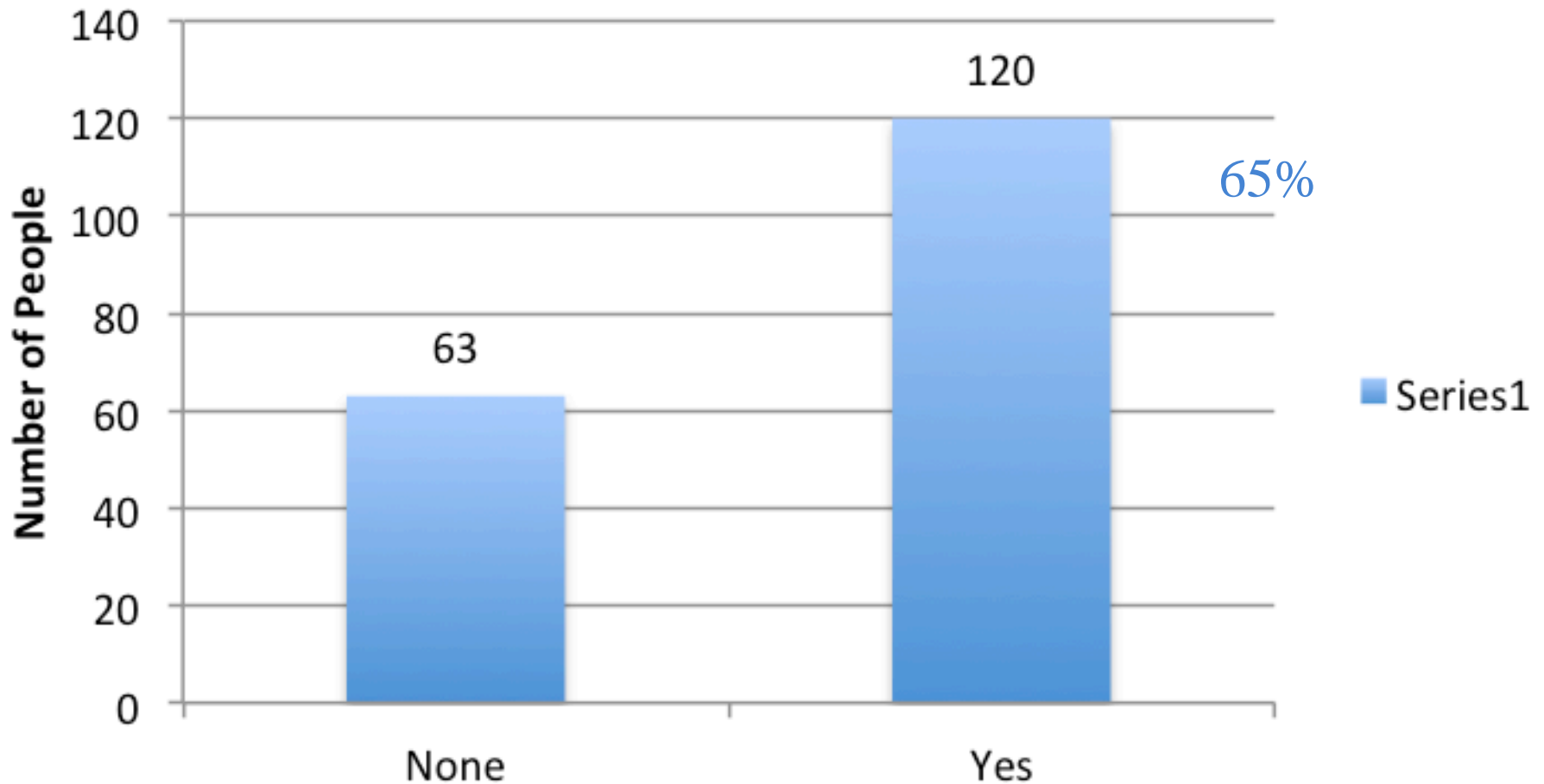


Over 40% of all OCHS patients had back pain as the primary reason for their opiate prescription in June 2015.

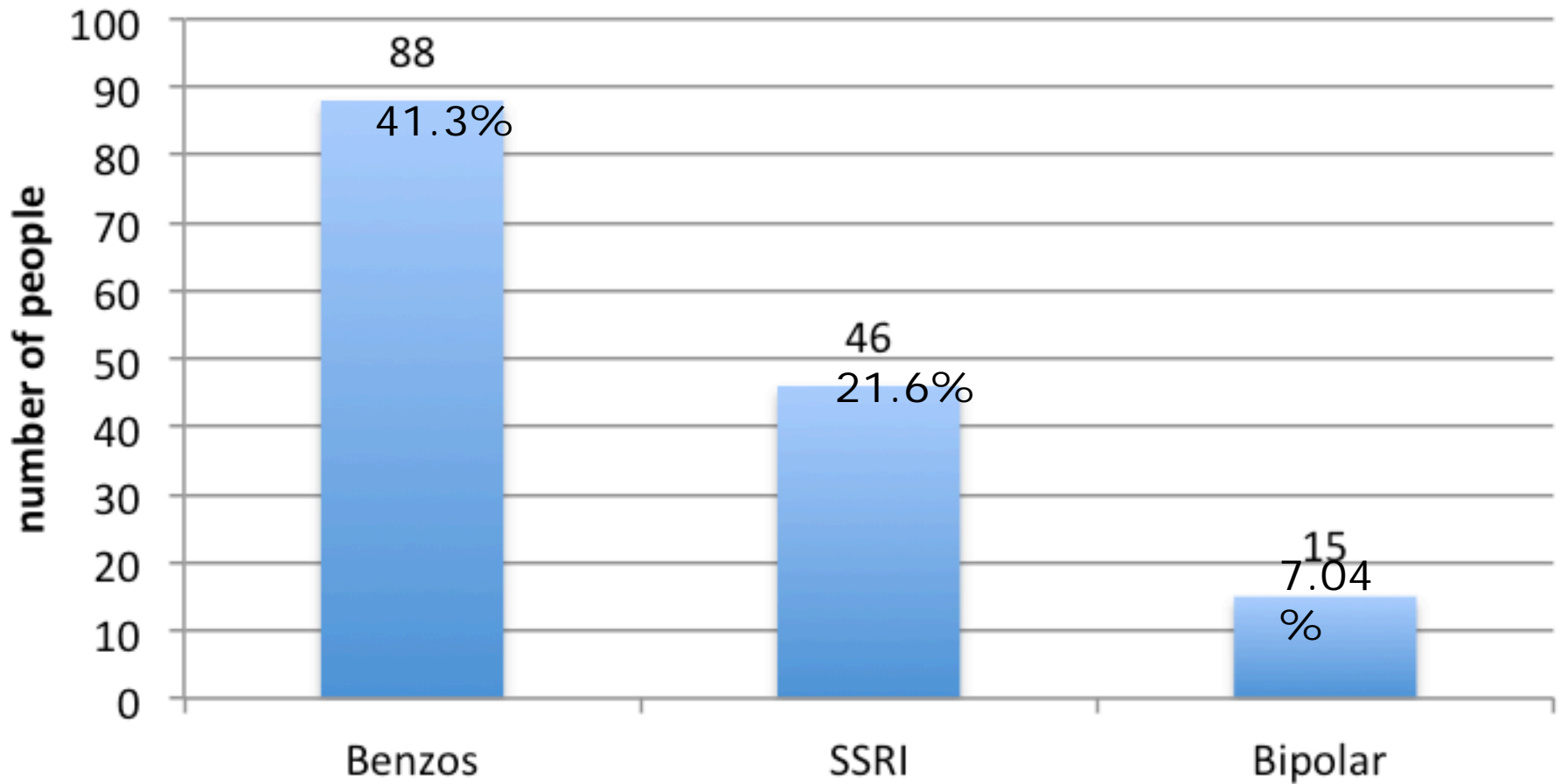
M.E.Q. Dosage - All OCHS



All OCHS - Psych Diagnoses



OCHS - Benzos v SSRI v Bipolar



Chronic pain case management: Two pronged approach

- * Optimizing risk management by PCP team
- * Changing prescriber behavior

Optimizing risk management

- * Better Pain assessment
- * Consistent Depression screening
- * Adding Informed consent to agreement form
- * Universal precautions by tier: agreements, PMP checks, UDS
- * Improving consistency of visits to PCP every 3 months

CPCM risk-benefit framework

FROM

- Is the patient good or bad?
- Does the patient deserve opioids?
- Should this patient be punished or rewarded?
- Should I trust the patient?

TO:

Do the benefits of opioid treatment outweigh the untoward effects and risks for this patient (or society)?

**Judge the opioid treatment,
NOT the patient, not the
prescriber**

Case management = Consistency

Many OCHS Patients are PCP/RN team case-managed:

- >200 patients with HIV case management
- >100 patients in Prenatal Program
- ~ 150 in OBOT (Suboxone)
- >200 complex chronic illness in care coordination

Improved pain assessment

- * Unidimensional pain scales are limited in usefulness
 - * Numeric “1-10”, visual, faces scale
- * Multidimensional instruments are better
 - * **PEG Scale** (Pain, Enjoyment, General Activity)
 - * “MA metric” at every visit for pain or refill
- * Incentive bonuses for MAs to capture PCP metrics

Trust issues

- * Some patients assume we don't believe their complaints
 - * Exaggerate pain scores and functional limitations
- * Some patients with adequate pain don't report relief
 - * Fear opioid analgesics will be reduced or stopped
 - * Fear provider will decrease efforts to diagnose cause of pain

Building relationships with patients

- * Validating patient's pain; empathy
- * Believing a patient's pain complaint does not mean opioids are indicated
- * Educating on need for accurate pain scores to monitor therapy
- * Continuity of care; team-based approach
- * PCP/MA bonuses for Quality metrics are in place



Jen, Nathan, Ingrid, Donna, Harwich OCHS Medical Assistant team

The PEG Scale

In the past week, how much:

Pain on average?



Pain interfered with **Enjoyment of life?**



Pain interfered with **General activity?**





Depression screening

- * Performed as part of primary care metrics since 2014
- * PHQ2
 - * If positive, then PHQ9, once a calendar year
- * If PHQ has been 5+ at last OV, repeat till under 5

National averages:

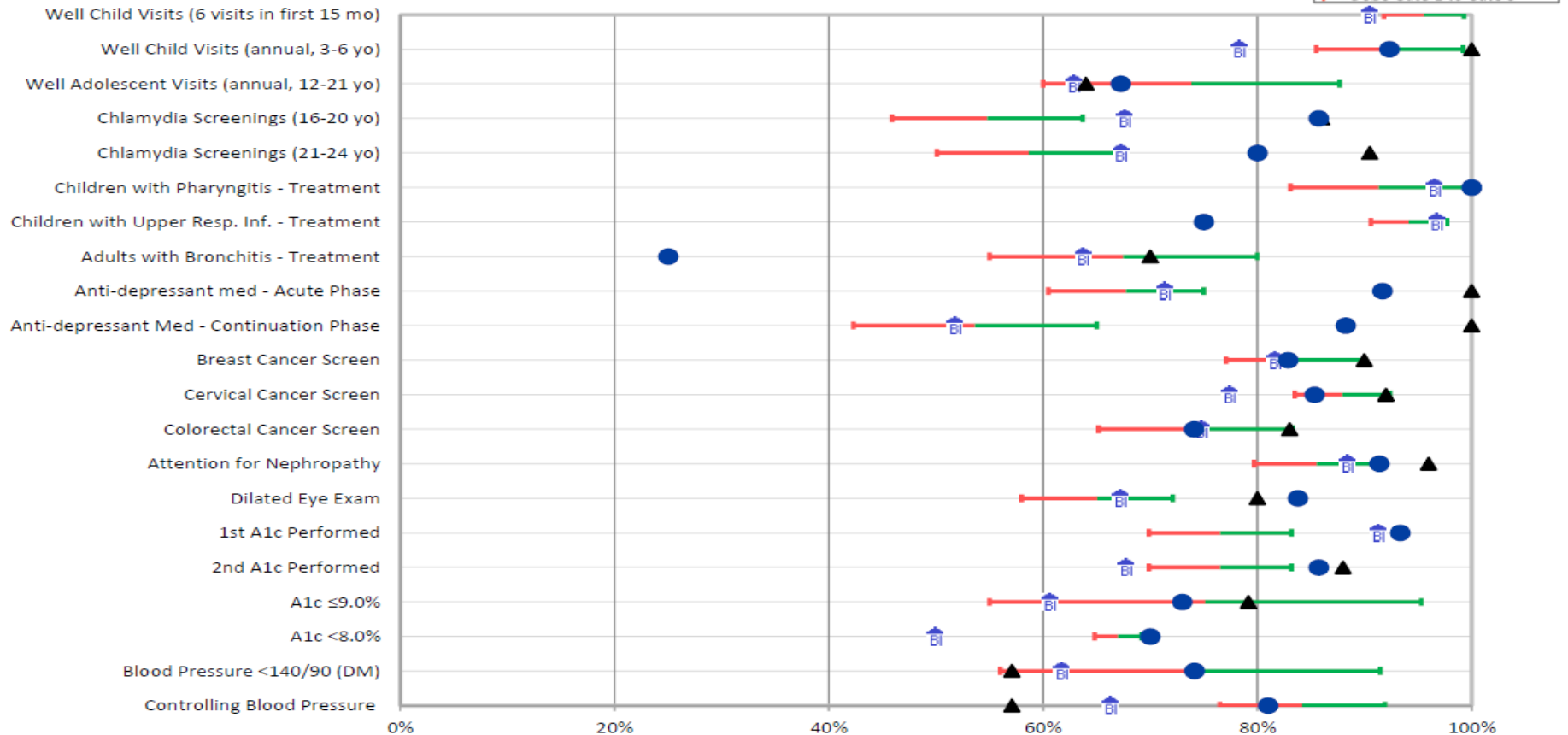
- * Depression 33-54%
- * Anxiety 16.5-50%
- * Personality Disorders 31-81%
- * PTSD 49% veterans, 2% civilians
- * Substance Use Disorders 15-28%

OCHS excellence in PCP metric capture

Beth Israel Deaconess | CARE ORGANIZATION

Affiliated with Beth Israel Deaconess Medical Center, Harvard Medical School, and Brigham Young University

**Figure 1: POD: [18] OUTER CAPE HEALTH SERVICES/
Practice: (All)/ PCPs: (All)
Commercial Payor Roll-up Report Date: 12-21-2015**



Opioid risks

- * Commonly recognized side effects: sedation, nausea, vomiting and constipation, itching, urinary retention
- * Potential adverse effects and toxicities with long term use: peripheral **edema**, immune system suppression (**reduced ability to fight infections** effectively), **hyperalgesia** (more pain rather than less pain), **sleep apnea** (which can be increased by benzodiazepine use with opiates), and changes in endocrine function, such as **low sodium levels**, which can promote a seizure. Methadone treatment specifically has been associated with certain **cardiac arrhythmias**.

Opiod risks (cont.)

- * Endocrine system effects: **reduced sexual function**, decreased libido, infertility, changes in menstrual periods, **decreased muscle mass** and strength, tiredness and **fatigue**, hot flashes & **night sweats**, mood disorders including **depression and anxiety**, osteoporosis, and osteopenia leading to higher **risk of fractures**.
- * Adverse effects are common but often unrecognized
- * **Respiratory depression** – sedation occurs before depression – if patients are sedated, the dose should be reduced
- * **New informed consent section** on OCHS controlled substance agreement
- * Longer form; PCP reviews #1, RN reviews annually

Opioid safety and risks, cont'd

- * Worsening of pain
 - * Withdrawal mediated pain
 - * Hyperalgesia in some patients
- * Addiction
 - * over 2/3 obtain opioids from friend or relative
 - * True incidence is unknown due to criteria used in studies – reported risk is 4-26%
- * Overdose
 - * At high dosages
 - * When combined with sedatives

Opioid misuse screen

- * Now in ROS
- * **OCHS prescriber encouraged to use once**
- * Known risk factors
 - * Age less than 45 years
 - * Personal history of substance use disorder
 - * Family history of substance use disorder
 - * Legal history
 - * Mental health problems
 - * History of sexual abuse

OPIOID RISK TOOL[®]

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
2. Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
3. Age (Mark box if 16 – 45)		[]	1	1
4. History of Preadolescent Sexual Abuse		[]	3	0
5. Psychological Disease	Attention Deficit Disorder	[]	2	2
	Obsessive Compulsive Disorder			
	Bipolar Schizophrenia			
	Depression	[]	1	1

TOTAL []

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

Universal precautions

- * No patient has 'zero' risk from opiates
- * 3 Tiers: High, Average, Low risk
- * Dummy code CPCM added to EMR problem list

Tiered risk structure

Tier 1

- MEQ 100mg+, or
- Benzodiazepines, or
- Red flags

Tier 2

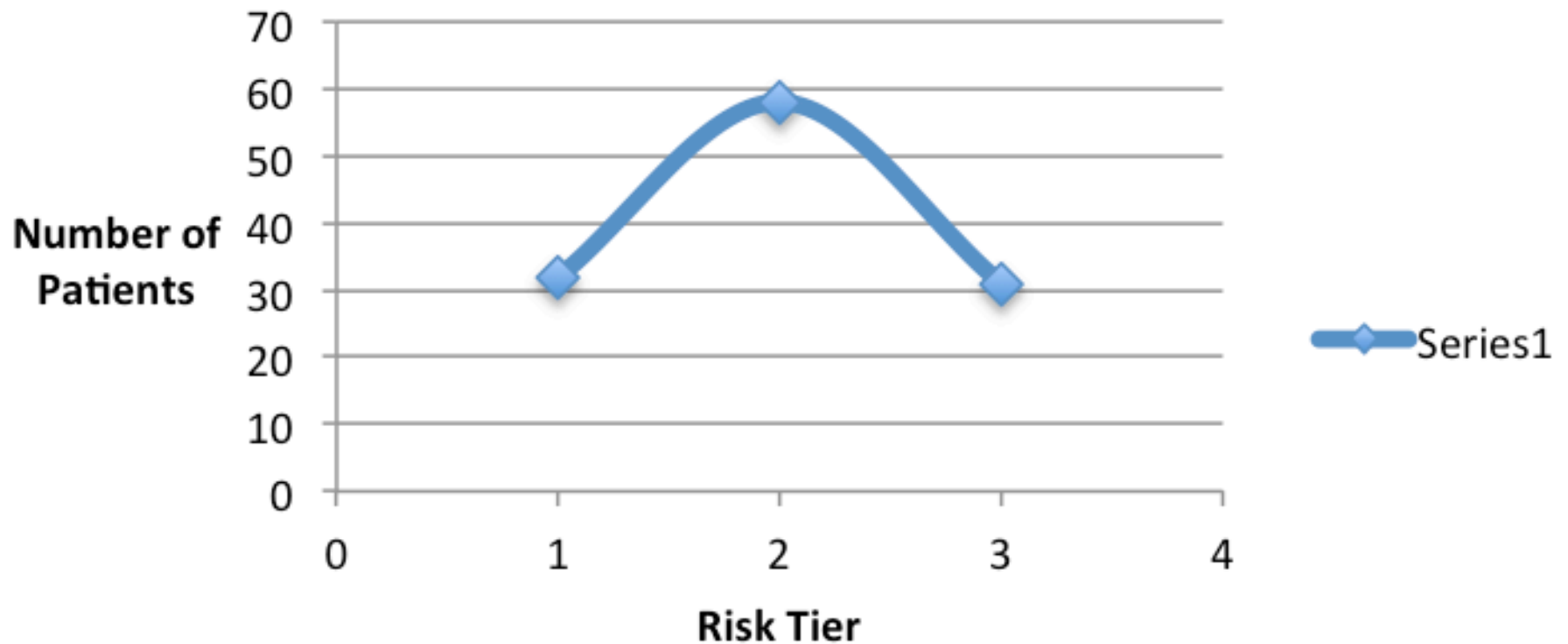
- Average MEQ
- No benzodiazepines
- No red flags

Tier 3

- Low MEQ
- No benzodiazepines
- No red flags

CPCM 1 Risk Tier “High risk”	CPCM 2 Risk Tier “Average risk”	CPCM 3 Risk Tier “Low risk”
PEG Scale		
<ul style="list-style-type: none">➤ MA asks pt to complete at visit, prior to PCP visit (paper form)➤ MA enters PEG info from form into ECW HPI “PEG” at visit➤ For example: P9, E8, G6=23➤ Discards paper form	Same	Same
Opioid Risk Tool		
<ul style="list-style-type: none">➤ Located in ROS➤ PCP completes risk assessment at least once (not once/year) for PCP information about risk	Same	Same
UDS capture by MA/RN		
<ul style="list-style-type: none">➤ Monthly➤ At visit or Rx pickup➤ RN prompts Rx in med closet/OV note➤ RN reminds PCP to order UDS monthly standing order	<ul style="list-style-type: none">➤ Quarterly➤ At visit or Rx pickup➤ RN prompts the prescription or OV note➤ RN reminds PCP to order monthly standing order	<ul style="list-style-type: none">➤ Annually➤ At visit or Rx pickup➤ RN prompts the prescription or OV note➤ Monthly standing order UDS at RN discretion
PMP (Physician Monitoring Program) check by RN delegate		
<ul style="list-style-type: none">➤ Quarterly➤ RN print/sign➤ To provider to sign/file➤ MA delegate may be assigned by RN➤ Delegates need to be notarized- see Medical Director for details	<ul style="list-style-type: none">➤ Every 6 months➤ RN print/sign➤ To provider to sign/file➤ MA delegate may be assigned to do this for PCPs by RN	<ul style="list-style-type: none">➤ Annual check➤ RN print/sign➤ To provider to sign/file➤ MA delegate may be assigned to do this for PCPs by RN
RN review of CPCM patient list at least monthly		
<ul style="list-style-type: none">➤ To ensure PCP OV every 3 months➤ RN (who can assign MA) to reach out to non-compliant pt to facilitate OV➤ To prompt upcoming OVs if UDS/contract due➤ To ensure new patients added appropriately and promptly for CPCM	Same	Same
Call-in for pill counts/UDS		
<ul style="list-style-type: none">➤ Random pill counts suggested quarterly➤ By RN or provider for any red flag➤ If patient seems inappropriate at Rx pick-up or OV, call-in within week➤ DNKA, call-in within week	Same	Consider random pill count periodically, otherwise, same

Bell Curve Risk Tier Chart: All OCHS



Changing provider behavior

- * Follow new MA and CDC guidelines
- * Expectations for tapering high MEQ
- * Optimizing safer strategies: **honest group discussion**
- * **Regularly scheduled meetings PCPs+RNs**
- * **Initially before now part of provider meeting, 2x mo**
- * Model best practices, practice your voice
- * **Team-building**, team support
- * Quarterly statistic tracking and provider incentives

Measures of success

- * See improvement in UDS, PMP, annual agreements (80% goal)
- * See decline on #s of patients on high dose opiates and on opiates
- * See more referrals to OCHS Behavioral health, decline in benzo use
- * Improvement in PCP satisfaction with care for patients with pain

Moving forward

- * Motivational interviewing (mindfulness? Simple stress reduction techniques?)
- * Alternative therapies for pain reduction (meditation, yoga, acupuncture?)
- * Modifying/disrupting of the provider-patient relationship?
- * Safety concerns?
- * Increased PCP team distress?
- * 2016 United Way grant proposal submitted to help fund CPCM nurse case manager

More questions

- * How to find balance; make sure putting patient's needs first?
- * Will placing more restrictions on scripts drive up heroin use in the community? Place stress on our OBOT program?
- * How best to identify and address addiction in pts w chronic pain?
- * How to prepare provider for potentially adversarial relationship with patient (new or existing)?
- * How to engage all of our PCP teams?
- * How to prevent provider burnout?



Summer is coming!

THANKS!